STATE OF MARYLAND
DHMH
Office of Health Services
Medical Care Programs

Maryland Department of Health and Mental Hygiene
201 West Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

PERSONAL CARE SERVICES AGREEMENT

This agreement is made this _____day of _____, 20 _____by and between the State of Maryland, Department of Health and Mental Hygiene, hereafter referred to as the "Department",_____ hereafter referred to as the "Provider" and _____ hereafter referred to as the "Recipient".

The Agreement is to be effective _____ and shall remain effective until:

1. The recipient is no longer eligible for Medical Assistance;
2. Personal care services are no longer appropriate for the recipient, i.e., the recipient is in need of a higher or lower level of care;
3. The Provider becomes unacceptable, i.e., fails to deliver services as agreed upon and/or performs in a manner which may be harmful to the recipient or fails to comply with applicable federal, State law, regulations, guidelines, etc; or
4. Either party gives written notice that service will be terminated. Except in cases where immediate termination is warranted.

In addition to the circumstances set forth above, the Department may immediately terminate this Agreement if the Provider:

1. Uses intoxicating or narcotic substances during service hours;
2. Causes the theft, mutilation, willful destruction, or other impairment of Recipient's property;
3. Participates in Program fraud; or
4. Acts in such a way as to endanger the health of the Recipient.

THE PROVIDER HEREBY AGREES BY INITIALING THE FOLLOWING:

1. That she/he understands the recipient's plan of care and is willing to begin personal care services on _____ at a frequency of _____ days per week. _____ Initials
2. That she/he will provide personal care services to the recipient in accordance with Personal Care Services Program regulations COMAR 10.09.20 and the recipient's individual plan of care and provider instructions. _____ Initials
3. That she/he understands that she/he is not an employee of the Department, but is a self-employed person acting in the capacity of an independent contractor. _____ Initials
4. To accept payment from the Department as payment in full for covered services and to make no additional charge for such services to the recipient or the recipient's family or friends. _____ Initials
5. To provide services without regard to race, color, national origin, political affiliation, age, physical or mental handicap, religion, sex or marital status. _____ Initials
6. That he/she is not a family member as defined by COMAR 10.09.20.01B(8). _____ Initials
7. To accept instruction and training in the provision of personal care services from the case monitor, other professionals; or the Department. _____ Initials
8. To submit completed invoices to the case monitoring agency for review and approval before submission to the Department for payment. (COMAR 10.09.20.03A(11)) _____ Initials

THE RECIPIENT HEREBY AGREES TO ACCEPT THE PROVIDER BY INITIALING THE FOLLOWING:

To accept the provider under the terms of this Agreement and the provisions of COMAR 10.09.20 as a provider of personal care services and understands that the provider is obligated only to provide those services specified in the written plan of care and covered in the regulations. _____
Initials

THE PROVIDER AND THE RECIPIENT HEREBY AGREE BY INTIALING THE FOLLOWING:

1. Understand that the Department will not be liable for damages and/or injuries received while services are being provided.
   _____ _____
   Provider Recipient
2. Understand that reimbursement for services will be paid by the Federal and State Governments and that any false claims, statements, documents or concealment of material facts will be prosecuted under applicable Federal and/or State laws.
   _____ _____
   Provider Recipient
3. Understand that the Department will not reimburse for services during a Recipient's hospitalization or nursing home stay.
   _____ _____
   Provider Recipient
4. Agree that this agreement is not transferable or assignable. _____ _____
   Provider Recipient

THE DEPARTMENT HEREBY AGREES:

To reimburse the Provider at the Level _____rate of service for each day services are provided to the Recipient while she/he is eligible for Medical Assistance and Personal Care Services Program benefits and for which a properly completed Provider Record Form (DHMH 311) and invoice are submitted for payment after such services have been provided. Reimbursable services must be provided in accordance with COMAR 10.09.20.

PROVIDER'S NAME	**RECIPIENT'S NAME**
ADDRESS	**ADDRESS**
PROVIDER PHONE# PROVIDER#	**RECIPIENT PHONE# M.A.#**
PROVIDER'S SIGNATURE	**RECIPIENT'S SIGNATURE**
DATE	**DATE**

CASE MONITOR'S SIGNATURE	**DATE**
DHMH/LHD SIGNATURE	**DATE**

DHMH 307 (REVISED 7/08)